Mission Hillsboro Medical Clinic

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Phone: (254) 479-1489 | Fax: (254) 283-5020
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VOLUNTEER APPLICATION

Name: _____ DOB: _____

Mailing Address, City, State, Zip: _____

Phone: _____ E-mail: _____

DL Number & State: _____ Expiration: _____

Skills & Certifications: _____

_____

_____

License Number: _____ Expires: _____

Area of Ministry Requested: Medical | Administration | Social Services | Translation

By signing, I affirm that I allow Mission Hillsboro Medical Clinic personnel to use the above information to perform a Criminal Background Check, and that, if needed, I will provide the clinic with any additional information to complete a Criminal Background Check.

_____ _____
Print Name Date

_____ _____
Signature Witnessed

Two References:

1. _____

2. _____

My photo can be used on MHMC Facebook page and website: Yes ___ No ____.

Please note: Background check is run on all volunteer applicants.